

**GOVERNMENT OF THE DISTRICT OF COLUMBIA**  
**Department of Health Care Finance**



**Fiscal Year 2022 Budget Hearing**

**Testimony of**  
**Wayne Turnage**  
**Deputy Mayor Health and Human Services**  
**Director Department of Health Care Finance**

**Before the**  
**Committee on Health**  
**Council of the District of Columbia**  
**The Honorable Vincent Gray, Chairperson**

June 7th, 2021  
10:00am  
WebEx Virtual Platform  
John A. Wilson Building  
1350 Pennsylvania Avenue, NW  
Washington, DC 20004

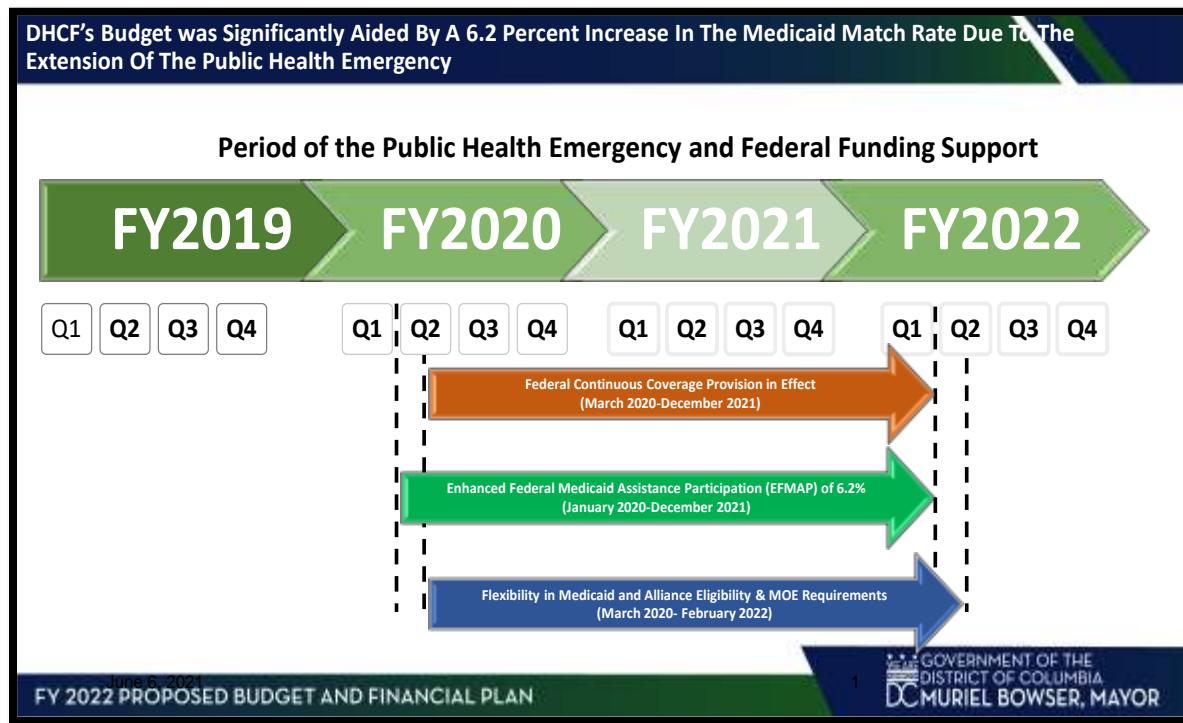
Good morning, Chairman Gray and members of the Committee on Health. I am Wayne Turnage, Deputy Mayor for Health and Human Services (DMHHS) and Director of the Department of Health Care Finance (DHCF). It is my pleasure today to report on Mayor Muriel Bowser's Fiscal Year 2022 (FY2022) Fair Shot Budget and Financial Plan for DHCF. I am joined by my executive and senior teams who have been instrumental in helping craft DHCF's budget proposals for the Mayor's consideration. Special recognition is due to the agency's Medicaid Director, Melisa Byrd, and our very capable Deputy Director of Finance, Angelique Martin. Their analytical efforts, in conjunction with the work of Darrin Shaffer, our Agency Fiscal Officer, have been instrumental in producing this budget.

### **Introduction**

We approached the FY2022 budget development process with a focus on the key priorities that have set the framework for DHCF over the past few years. Recall that our three priorities for the programs we administer, align with the major reforms that are underway at DHCF. These priorities are:

1. Build a health system that provides whole person care.
2. Ensure value and accountability in the services program members receive.
3. Strengthen the internal agency operational infrastructure.

As we focused on these priorities, the FY2022 budget development across the District and within DHCF was significantly and favorably impacted by the extension of the federal Public Health Emergency (PHE). In establishing the PHE, the goal of the federal government was to ensure, among other things, continuous health care coverage for American citizens during the pandemic. As shown on the next page, the District received an increase in its federal matching



rate of 6.2 percent to fund the requirements of sustained coverage for Medicaid enrollees throughout the pandemic into the second quarter of FY2022.

Further, the District's PHE also provides flexibility for DHCF in enrolling and recertifying D.C. Healthcare Alliance (Alliance) members. Should the District's PHE be extended further to align with the federal PHE, the continuous enrollment period without recertification will continue through February 2022. This extension allows Alliance enrollees to continue receiving health care insurance without having to visit a service center for recertification.

When combined with the aggressive set of eligibility policies for both Medicaid and the Alliance programs that existed in the District of Columbia prior to the pandemic, the PHE coverage extensions created significant cost pressures for DHCF's budget which were recognized and funded, in part, by the enhanced Medicaid match rate.

## The Complex Factors Which Impacted DHCF's FY2022 Budget Development Process

In constructing the agency's budget for FY2022, we spent considerable resources on efforts to understand the impact of major program changes on Medicaid and Alliance enrollment, utilization patterns, and current cost. Our principal goal in evaluating these changes was to assess and quantify what this meant for DHCF's budget projections in FY2022.

The multiple factors and their impact on enrollment and utilization is discussed in the table below. The PHE and DHCF's transition of certain adult beneficiaries from the fee-for-service (FFS) program to managed care have had varying and significant impacts on enrollment levels, utilization, and costs which had to be accounted for in budget development.

Competing Factors Influenced Enrollment and Utilization Trends		
The Public Health Emergency and DHCF's transition of certain adult beneficiaries from FFS to the MCO program have had varying and significant impacts on enrollment, utilization and costs. The net effect is a decline in overall budget for provider payments.		
Key Event	Impacts on Enrollment and Utilization	Budget Impact
Beginning of PHE	<ul style="list-style-type: none"><li>Increased enrollment due to continuous coverage provisions resulting in suspension of eligibility redetermination</li><li>Decreased utilization of well visits and elective procedures</li><li>Increased enrollment due to increased unemployment rate and therefore more residents becoming financially eligible</li></ul>	<ul style="list-style-type: none"><li>Increased per-person cost due to incidence of costly COVID-19 related acute stays</li><li>Increased enrollment resulting in more capitation payments</li><li>Provider rate enhancements increased cost for certain services</li></ul>
FY21 Transition of Adult populations from FFS to MCO	<ul style="list-style-type: none"><li>Decreased enrollment in FFS</li><li>Increased MCO Enrollment</li><li>Population remaining in FFS are sicker and therefore more costly</li></ul>	<ul style="list-style-type: none"><li>Overall FFS cost is lower, but per-person cost is higher because healthier FFS population moved to MCO</li><li>MCO cost are higher due to increased population shift from FFS, but the per-person cost aligned with the MCO case mix</li></ul>
End of PHE	<ul style="list-style-type: none"><li>Continuous coverage provision ends</li><li>Allows eligibility redetermination to resume, resulting in enrollment drops</li><li>Increased employment rates creates, decreased Medicaid eligibility</li></ul>	<ul style="list-style-type: none"><li>Decreased enrollment results in decreased utilization and monthly capitation payments</li><li>Decrease in COVID-19 related acute hospitalizations</li></ul>

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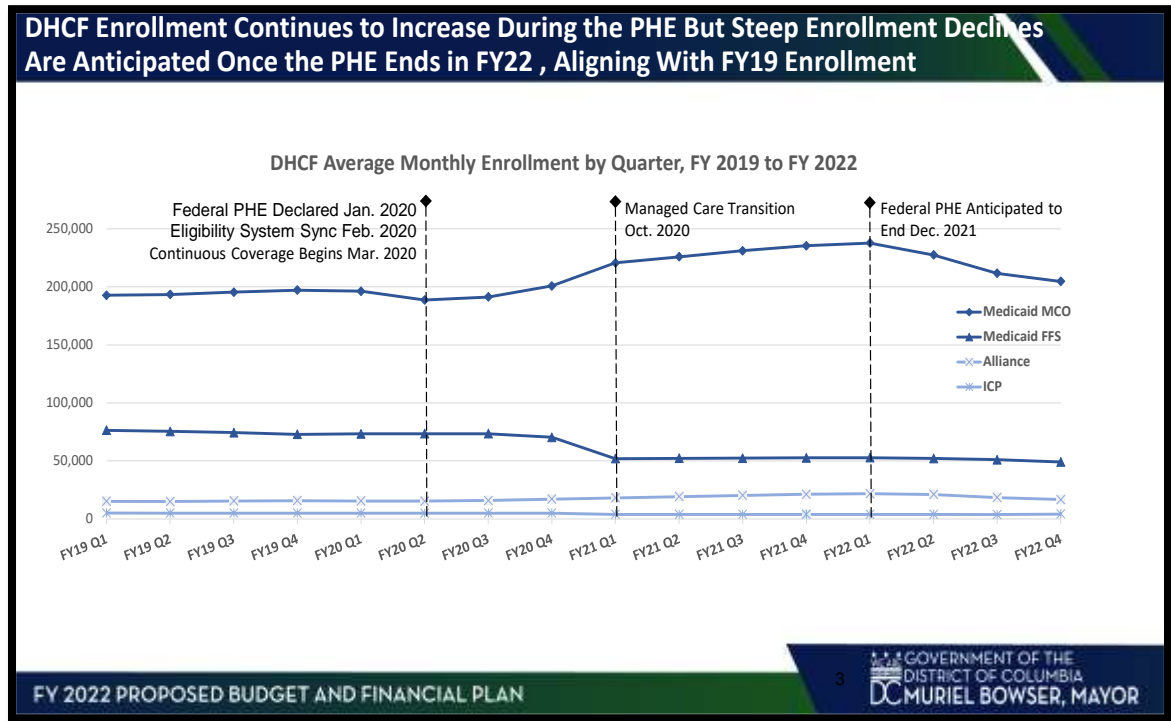
Accounting for anticipated enrollment changes is especially challenging. While historical health care cost data are often reliable predictors of future cost, the relationship between past and future enrollment levels cannot often be summarized with straight line projections. This creates

some risk in budget formulation. If we overestimate the enrollment increases in formulating the FY2022 budget, the agency will be left with a significant surplus based on actual spending. In effect, this would mean reserving valuable funds for DHCF programs that could have been allocated by the Mayor and the Council to other critical areas of the budget for the entire city. As mentioned earlier, this was a problem in FY2021 when enrollment did not grow as significantly as projected in response to the pandemic and the associated economic downturn, causing an excess allocation of budget funds to the agency.

Conversely, if we badly underestimate future enrollment patterns, DHCF will face significant spending pressures because of the entitlement nature of both Medicaid and the Alliance programs. For example, we cannot suspend enrollment and curtail payments if we discover that there are insufficient funds in the agency's budget to address higher than expected enrollment and utilization levels observed for the entire fiscal year.

Thus, the challenge in developing enrollment projections for this budget was quantifying the change DHCF anticipates will occur when the coverage extensions for Medicaid and Alliance conclude at the end of the PHE. The graphic on the next page provides the agency's estimate of this dynamic. As is illustrated, for FY2022, when the PHE ends, we are predicting a steep decline in the largest program within Medicaid—managed care—and very limited to no growth in the other programs. The net effect of these adjustments is an overall decline in expected enrollment.

Mr. Chairman, for the remainder of my testimony today, I will focus on the agency's budget structure and the year over year changes in the key components that shape the Agency's spending plan. In addition, I will report on the budget development process with special attention to how we built DHCF's \$3.6 billion spending plan, including investments made by the Mayor in support



of health care delivery in the city. As will be demonstrated, the Mayor's FY2022 budget for DHCF holds down personnel spending, while embracing the city's historical reputation for ensuring health care access to the full array of preventive, diagnostic, emergency, speciality, and acute services.

### DHCF's Budget Structure

As we have reported in the past, DHCF's budget is supported by six funding types, the most significant being the federal Medicaid Entitlement Grant and the agency's local fund source. The others are dedicated taxes, federal grants, Intra-District funds, and special revenue funds. The table on page 7 lists these six funding sources and illustrates the variance from the amounts in DHCF's FY2021 approved budget to the Mayor's proposed spending plan for FY2022.

**Due To Anticipated Enrollment Declines And The End of Federal COVID Relief, The Increase In DHCF's FY2022 Budget Is A Modest One Percent**

	LOCAL	DEDICATED TAXES	FEDERAL PAYMENTS	FEDERAL GRANT	FEDERAL MEDICAID PAYMENTS	SPECIAL PURPOSE REVENUE FUNDS ('O'TYPE)	OPERATING INTRA-DISTRICT FUNDS	Total
FY 2022 Proposed Budget (1 Qtr. COVID-19)	846,752,958	103,219,385	1,500,000	3,206,819	2,544,794,223	6,434,236	138,651,816	3,644,559,437
FY 2021 Approved Budget (Full Year COVID-19)	857,622,717	98,195,140	-	6,067,676	2,472,818,580	6,596,710	138,715,711	3,580,016,534
FY 2020 Expenditures (3 Quarters COVID-19)	716,795,591	78,423,261	-	1,213,681	2,545,302,473	1,395,253	98,199,784	3,441,330,043
FY 2019 Expenditures (Prior to COVID-19)	774,523,518	81,015,396	-	1,190,712	2,263,036,125	1,610,580	102,484,928	3,223,861,259
FY22/FY21 YoY Change	-1.27%	5.12%		-47.15%	2.91%	-2.46%	-0.05%	0.91%

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Overall, the Mayor's planned spending proposal for DHCF is roughly one percent higher than the approved budget in FY2020. The significant decline in federal grant money (47 percent) and the minuscule year-over-year decline in local funding respectfully, are due to the anticipated expiration of the PHE and falling enrollment reductions.

However, the minor change in planned local spending is somewhat misleading. Notably, in FY2021, the Mayor's supplemental budget reduced DHCF's local funding by \$95 million due to several factors, including a surplus because enrollment had not grown as projected, a drop in Medicaid program cost based on reductions in utilization due to the pandemic, and increased federal Medicaid reimbursement during the PHE. If the year-over-year change in local funding is determined from the adjusted budget in FY2021, the local fund increase is just over 11 percent.

When each of the funding types are summarized, DHCF's FY2022 proposed budget, increased by a total of \$64.5 million. As the table below demonstrates, payments to providers are responsible for nearly the entire increase as both DHCF staff levels and key components of the agency's administrative cost structure either experienced minimal increases or were reduced from the approved FY2021 budget.

The FY2022 Budget Increase of \$64.5M over FY2021 Mainly Attributed to Provider Payments						
Spending Category	FY22 Proposed Budget	FY21 Approved Budget	Variance	FY 2020 Expenditures	FY22 Proposed FTE's	FY21 Approved FTE's
0011-REGULAR PAY - CONT FULL TIME	34,263,485	34,436,169	(172,683)	28,139,386	329.99	327
0012-REGULAR PAY - OTHER	1,549,495	2,091,846	(542,351)	1,390,097	21.04	27.02
0013-ADDITIONAL GROSS PAY	-	-	-	170,380	0	0
0014-FRINGS BENEFITS - CURR PERSONNEL	7,909,963	7,788,031	121,932	6,406,100	0	0
0015-OVERTIME PAY	-	-	-	12,940	0	0
<b>PERSONNEL SERVICES Total</b>	<b>43,722,943</b>	<b>44,316,046</b>	<b>(593,103)</b>	<b>36,118,902</b>	<b>351.03</b>	<b>354.02</b>
0020-SUPPLIES AND MATERIALS	200,953	221,492	(20,539)	93,748	0	0
0030-ENERGY, COMM. AND BLDG RENTALS	408,722	355,841	52,880	262,933	0	0
0031-TELECOMMUNICATIONS	388,939	377,255	11,685	330,864	0	0
0032-RENTALS - LAND AND STRUCTURES	1,453,414	1,890,175	(436,761)	1,340,880	0	0
0034-SECURITY SERVICES	309,203	303,123	6,080	91,879	0	0
0035-OCCUPANCY FIXED COSTS	434,858	549,525	(114,667)	441,312	0	0
0040-OTHER SERVICES AND CHARGES	2,179,178	3,289,913	(1,110,735)	5,525,480	0	0
0041-CONTRACTUAL SERVICES - OTHER	171,735,006	157,377,097	14,357,909	113,069,355	0	0
<b>0050-SUBSIDIES AND TRANSFERS</b>	<b>3,410,605,086</b>	<b>3,348,957,156</b>	<b>61,647,930</b>	<b>3,283,211,227</b>	<b>0</b>	<b>0</b>
0070-EQUIPMENT & EQUIPMENT RENTAL	13,121,134	22,378,911	(9,257,777)	843,462	0	0
<b>NON-PERSONNEL SERVICES Total</b>	<b>3,600,836,494</b>	<b>3,535,700,488</b>	<b>65,136,006</b>	<b>3,405,211,140</b>	<b>0</b>	<b>0</b>
<b>Grand Total</b>	<b>3,644,559,437</b>	<b>3,580,016,534</b>	<b>64,542,903</b>	<b>3,441,330,043</b>	<b>351.03</b>	<b>354.02</b>

## DHCF's Budget Development Process

Mr. Chairman, at this point, I would like to discuss the budget development process for DHCF and illustrate the actions taken to shape our proposed FY2022 budget. Public health safety measures altered the traditional process for community engagement. Rather than have the normal budget town halls across multiple wards, the Mayor led a virtual process where deputy mayors



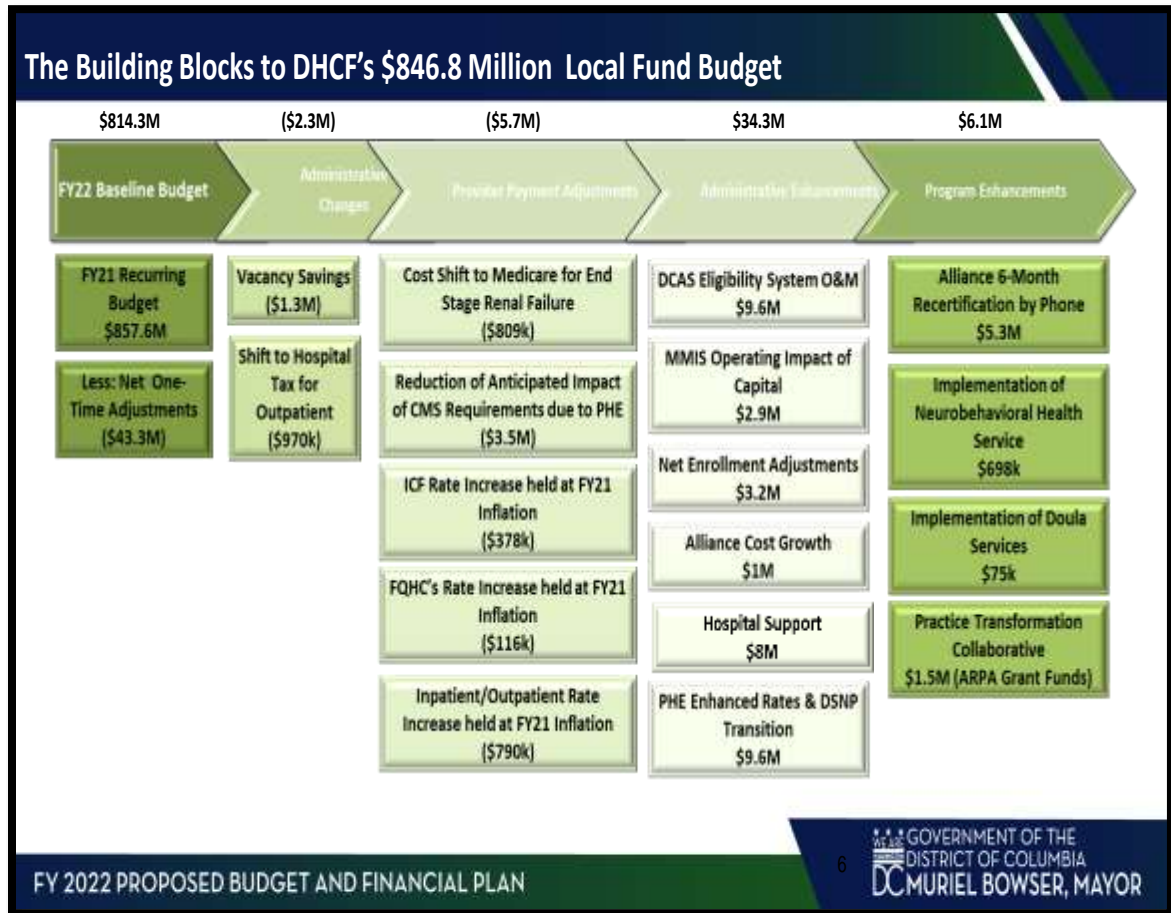
outlined their cluster agencies' mission and goals, and then community members provided input through online voting.

A significant factor in the budget process this year was the amount of funding made available to the states through the American Recovery Plan Act of 2021. This much needed infusion of federal funds was critical in stabilizing the District's budget, allowing the Mayor to make major and targeted investments in each of the functional areas of government, including health and human services.

*Budget Development.* The building blocks for DHCF's FY2022 budget are outlined in the table on page 10. As shown, DHCF began the process with a FY2021 recurring local fund budget of \$857.6 million. This amount was adjusted downward by \$43.3 million in DHCF's provider payment budget, mostly due to enrollment decreases, and for cost associated with grants and other initiatives.

*Savings Initiatives.* Through both administrative changes and provider payment adjustments, DHCF recommended and the Mayor accepted \$8 million in savings. The largest component of these savings (\$3.5 million) were realized after evaluating the impact of: (1) PHE-related requirements for the nursing home industry from the Centers for Medicare and Medicaid Services (CMS); (2) anticipated rate increases based on inflation of FY2018 audited cost; and (3) anticipated enrollment decline.

Administratively, DHCF produced \$1.3 million in vacancy savings. We also used revenue from the hospital provider tax to fund \$970,000 in outpatient services for the FFS Medicaid population, freeing up local dollars in the process. Moreover, we shifted to Medicare, the Medicaid cost of treating end stage renal failure for persons who are dually eligible for both programs.



DHCF also generated small savings from freezing inflation rates at FY2021 levels for several provider groups.

*Administrative Enhancements.* The Mayor funded \$34.3 million in administrative enhancements for DHCF. These actions cover a range of programs including:

- \$9.6 million to fund the operations and maintenance cost of the DCAS eligibility system;
- Over \$2.9 million to support the operations of DHCF's Medicaid Management Information System;
- \$3.2 million to cover the cost of care for anticipated Medicaid enrollment growth in FY2022;

- \$1 million to cover the growing cost of the Alliance, due both to sustained and increasing eligibility, along with the rising per-participant cost witnessed for the program;
- \$8 million to cover the loss of Disproportionate Share Hospital (DSH) funding for Howard—a problem created by a federal change to DSH that produced the unintended consequence of a \$21 million loss in funds for the hospital; and,
- \$9.6 million to cover the enhanced rates DHCF will continue to pay during the PHE to nursing homes, federally qualified health centers, home health agencies, community-based waiver programs, and Intermediate Care Facilities for Individuals with Intellectual Disabilities.

*Program Enhancements.* In addition to the administrative enhancements, the Mayor funded \$6.1 million in targeted program enhancements. While these actions fund four separate initiatives, almost 87 percent of the funding for these enhancements is allocated for the Alliance program. The funding will support the continuation of legislation that provides Alliance participants with the option to recertify by phone.

Mr. Chairman, we are aware that you and Councilmember Briana Nadeau have long desired an end to the face-to-face certification requirement that Alliance members encountered every six months that they were enrolled in the program prior to the pandemic. Based on the legislation sponsored by Councilmember Nadeau, concerns about the burdens imposed by this administrative device, and the attendant problems of adverse selection, the Mayor will continue the no face-to-face certification policy that was first initiated during the pandemic. Keeping this policy in place for FY2022 will allow both DHCF and the Mayor's executive budget office to use the additional enrollment and cost data from that year to better pinpoint and fund the permanent cost of this change in the Mayor's FY2023 budget and going forward.

### **Ensuring Equitable Provider Rates**

As you know Mr. Chairman, the enhancements listed in the Mayor's budget are only a fraction of the total planned spending for health care programs in DHCF. In exchange for an

agreement to pay a portion of the states' costs for the Medicaid program, the Center for Medicare and Medicaid Services (CMS) mandates certain benefits to be covered as a part of each state's Medicaid Plan, while also establishing a comprehensive list of services as optional. However, as the table below reveals, the optional services include many benefits that no robust health care program can effectively exclude.

The District is Required by CMS to Provide Certain Benefits and Others are Determined Optional Benefits by CMS	
Mandatory Service Benefits	Optional Service Benefits
<ul style="list-style-type: none"><li>• Inpatient hospital services</li><li>• Outpatient hospital svcs. (incl. Emergency Room)</li><li>• EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services</li><li>• Nursing Facility Services</li><li>• Home health services</li><li>• Physician services</li><li>• Federally qualified health center services</li><li>• Laboratory and X-ray services</li><li>• Family planning services</li><li>• Nurse Midwife services</li><li>• Certified Pediatric and Family Nurse Practitioner services</li><li>• Freestanding Birth Center services (when licensed or otherwise recognized by the state)</li><li>• Transportation to medical care</li><li>• Tobacco cessation counseling for pregnant women</li></ul>	<ul style="list-style-type: none"><li>• Prescription Drugs</li><li>• Clinic services</li><li>• Physical therapy and Occupational therapy</li><li>• Speech, hearing and language disorder services</li><li>• Other diagnostic, screening, preventive and rehab. svcs</li><li>• Podiatry svcs, Optometry svcs &amp; Other practitioner svcs</li><li>• Dental Services and Dentures</li><li>• Prosthetics, Eyeglasses</li><li>• Private duty nursing services</li><li>• Personal Care</li><li>• Hospice</li><li>• Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)</li><li>• Intermediate care facility for Individuals with IDD</li><li>• Adult Day Health Program</li><li>• Inpatient psychiatric services for individuals under age 21</li><li>• Health Homes Programs</li></ul>

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The focus on the Mayor's targeted investments in my testimony is not intended to exclude or overshadow her commitment to the District's legacy of extensive coverage and comprehensive benefits for 40 percent of the city's residents. Much of the Mayor's proposed budget allocates the necessary funds to support Medicaid and Alliance enrollee utilization levels across the myriad of

services. This explains why provider payments account for nearly 95 percent of DHCF's \$3.6 billion proposed budget for FY2022—an amount that consistently stands across budget years.

The table below provides a comparison, by health care service, of proposed spending in FY2022 with the approved budget for FY2021. This table also reports actual FY2020 spending levels for these services. For some services, the proposed FY2022 budget indicates a reduction in funding. In reviewing these data, it is important to remember that the proposed funding levels for the Mayor's DHCF budget submission are determined by the agency's analysis of historical Medicaid and Alliance utilization. From this information, expected future cost are discerned using data on both the unit cost of a service and the number of enrollees who used the benefits.

Some Provider Payment Budgets Decrease Due To Declining Enrollment in FY22, But Equitable Rates Will Still Be Implemented Based on Cost			
	1 Qtr. PHE & Post Transition of FFS to MCO	12 Months PHE and 1 <sup>st</sup> Yr. Transition of FFS to MCO	9 Months PHE and Pre Transition
Services	FY22 Proposed Budget	FY21 Approved Budget	FY20 Expenditures
Alliance	112,947,242.31	101,713,378.03	90,274,253.98
Behavioral Health	163,511,745.66	162,597,482.49	134,591,760.46
Clinic Services	46,446,501.99	24,949,669.34	73,339,305.14
Home Health Services	14,945,428.84	17,639,376.78	19,451,471.85
Hospital Services	191,495,043.60	222,249,939.33	383,152,108.51
Long Term Care	1,059,286,055.68	969,560,039.38	1,036,172,171.92
Managed Care	1,475,657,863.23	1,514,929,613.18	1,170,570,990.23
Other Services	217,600,315.01	218,435,853.62	208,026,800.28
Pharmacy	27,177,198.25	29,545,756.50	48,848,466.83
Physicians and Nursing	17,201,773.13	31,045,562.92	49,730,484.16
Public Provider	73,329,100.00	41,369,100.00	54,673,747.60
Hospital Support	8,000,000.00	-	8,750,000.00
<b>Grand Total</b>	<b>3,407,598,267.70</b>	<b>3,334,035,771.57</b>	<b>3,277,581,560.96</b>

- In FY20, spending includes a larger FFS population in comparison to FY21 and FY22; as well as 9 months of PHE Provider Relief payments and higher enrollment due to flexibilities in eligibility
- In FY21, spending includes the transition of specific adults from FFS to MCO, continued PHE Provider Relief payments and a growing population due to continued flexibilities in eligibility
- In FY22, the spending projects
  - 3 months of Provider Relief thru the end of the pandemic (estimated to end December 2021)
  - Forecasted decline in enrollment due to the expiration of flexibilities in eligibility during the PHE
  - Scheduled rate adjustments

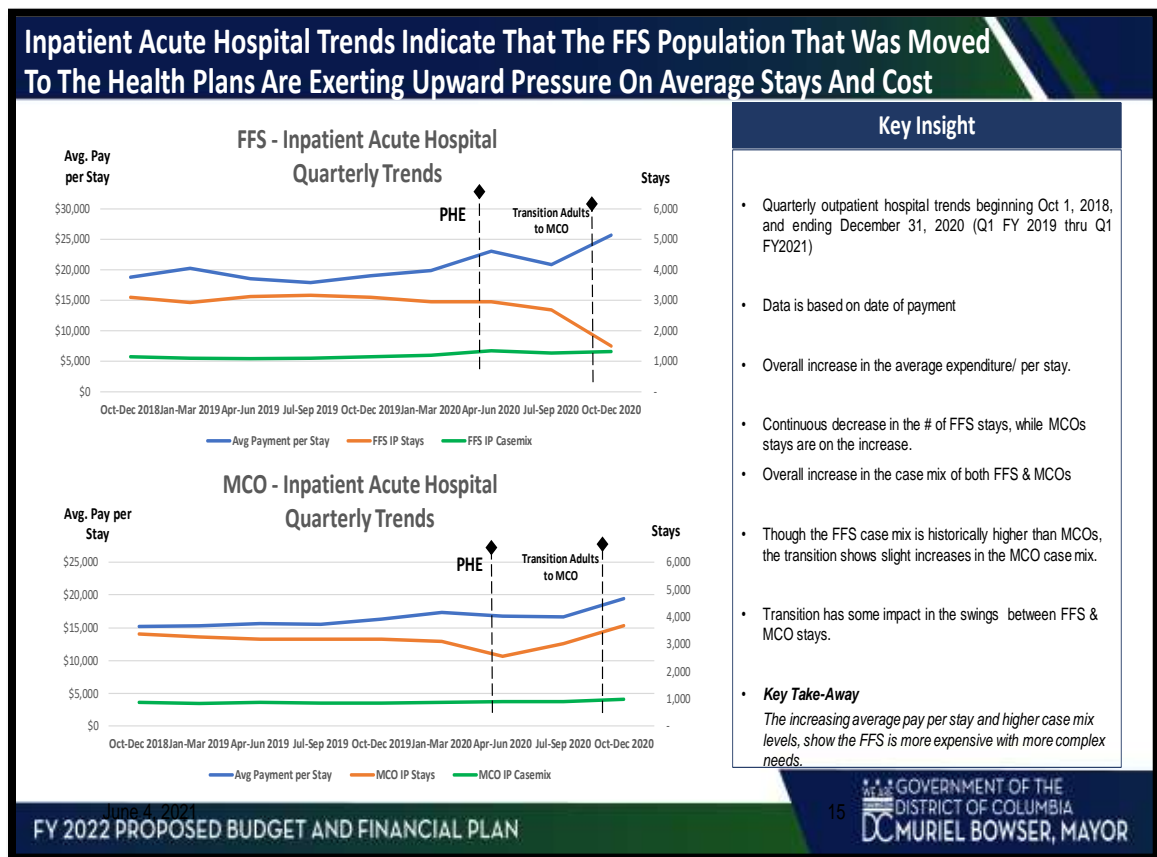
NOTE: Long Term Care includes Nursing Facility, ICF/IID & EPD and DD Waivers. Other Services include DME, Pharmacy, Medicare Parts A&B; Hospital Supports in FY20 represents a portion of the Surge Grants and in FY22 funding for hospitals providing care to vulnerable populations

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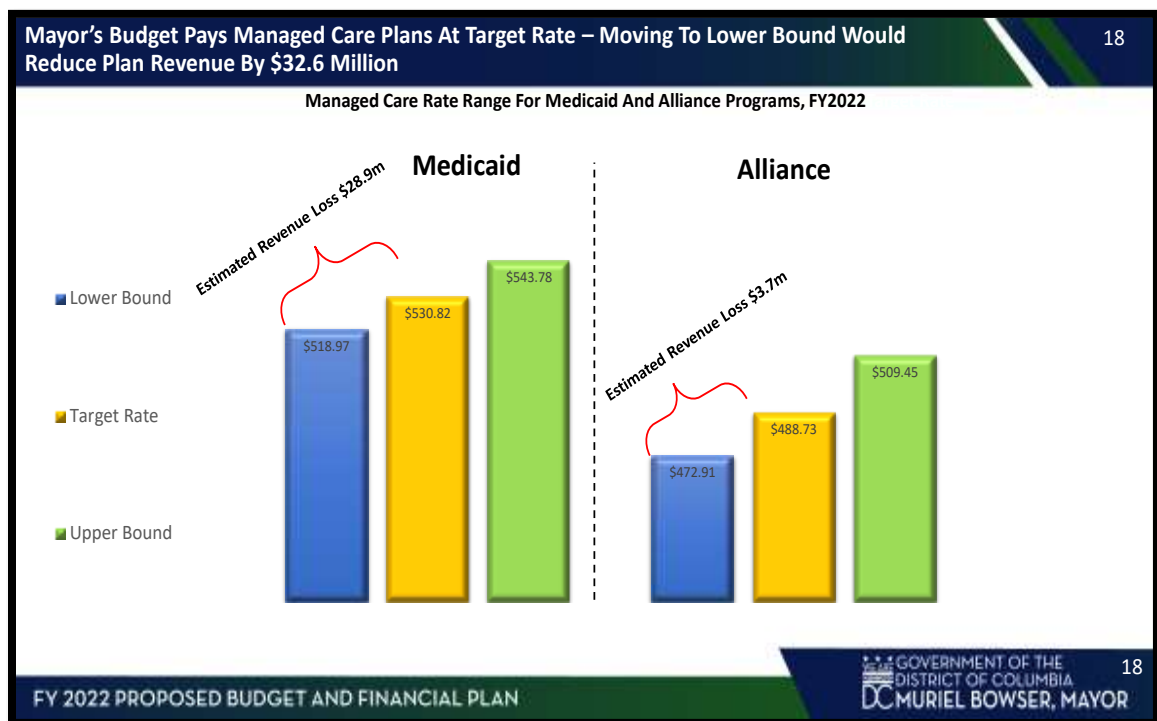
This fact takes on special importance for FY2022 because of three factors which directly impact historical utilization and predicted funding levels. First, in FY2020, Medicaid spending included a larger FFS population in comparison to FY2021 and FY2022. Recall that we moved more than 16,000 FFS members to managed care at the start of FY2021. In addition, there were nine months of PHE Provider Relief payments and higher enrollment due to flexibilities in eligibility. This will, for some services, inflate cost to levels that might not persist in later years.

Second, the transition of specific adults from FFS to managed care, continued PHE Provider Relief payments, and a growing population due to allowable flexibilities in eligibility processing for enrollees, will dramatically lower FFS spending in hospitals, but could increase revenues generated by health plans whose rates will reflect the higher expected cost from the transfer of some FFS residents into managed care. The graphic below illustrates this phenomenon.



This is why it is important to maintain the rates in the Mayor's budget for managed care plans. As the State Medicaid agency, DHCF is allowed to set rates at the upper, mid-point, or lower bound of an actuarially determined rate range. Unless the District is experiencing fiscal stress, DHCF's policy is to recommend the mid-point, or so-called target rate, as the payment level for the health plans. This rate has the highest statistical confidence against persistently over or under paying Medicaid-funded health plans.

As you recall, a proposal was introduced in Council to reduce managed care rates from the level in the Mayor's budget to the lower bound for the next four years, absent a decision by DHCF to retain three health plans in the program. The graphic below highlights the revenue consequences that would be associated with such a decision. As shown, revenue to the health plans would decline by more than \$32.6 million. Under the initially proposed bill, this revenue loss -- and possible more -- will occur over the next four years and will undoubtedly echo through the rates that are paid by the managed care plans to the District's health care providers.



Finally, in FY2022, the planned spending for services or projects reflected three months of provider relief which will be provided through the end of the pandemic, currently estimated for December 2021. As a result, DHCF forecasted a decline in expected enrollments which we believe will occur with the wind down of pandemic activities.

Notwithstanding the declines or increases predicted for FY2022 in the Mayor's budget, DHCF will ensure that rates are equitably established as we receive provider cost reports that offer greater detail on actual cost. In some cases, we may discover that the higher spending projected in the Mayor's budget may decline if a given provider's cost continues to drop. In other cases, DHCF may discover that reported cost has grown at a level with some providers that may justify higher rates and payments than previously assumed. Under either circumstance, DHCF's Finance Deputy and her team will build reimbursement models that address both equity and adequacy in the rate setting process.

### **Status of Key Medicaid Procurements**

Lastly Mr. Chairman, because of the central importance of this issue, I close my testimony by providing an update on the status of three Medicaid contracts. The impact of proposed legislation drafted by the Mayor that would allow three essential DHCF contracts impacted by a protest to move forward is significant and cannot be overlooked. As my testimony detailed at your hearing on this proposed legislation last month, we have determined that the consequence of failing to enact this legislation amounts to approximately \$5.4 million in additional costs and lost opportunities to draw down federal funds. The details are as follows:

- \$715,000 to procure a managed care enrollment broker to ensure that the seamless transition of ~60,000 beneficiaries from Medstar to AmeriHealth and Carefirst;
- \$4.3 million due to the increase in cost allocation for the DCAS Application Development contract; and



- \$400,000 to restart the existing MMIS contract instead of re-procuring a new vendor.

Given the Mayor's foresight to also include the legislative changes in a proposed subtitle in the Fiscal Year 2020 Budget Support Act of 2021, the Council still has a chance to mitigate the major disruption in three DHCF's programs and, in the process, prevent an adverse agency financial impact.

There has been, as you know, special attention on the Medicaid managed care contracts. These contracts were re-procured in 2020 to address the problem of adverse selection – a problem which leads to financial ruin for some plans and unjust profits for others. DHCF added language to the new request for proposals that provides important program and financial safeguards for the contracts that were ultimately awarded to AmeriHealth, CareFirst, and MedStar Family Choice (MedStar).

Subsequently, Amerigroup, which finished 4th in the competitive range, raised several complaints of the award to MedStar. Notably, the filed protest contended that:

- Points that Medstar received for the technical merits of proposal were too high due to absence of documentation for 2 staff positions.
- Medstar's score for past performance was too high based on the use of 2 versus 3 references.
- Medstar's score for past performance reflected a more favorable treatment of Medstar than Amerigroup for similar problems.

Amerigroup also requested documents on MedStar's Certified Business Enterprise (CBE) plan submission to examine whether it was compliant with CBE law on the technically narrow question of timeliness – this was the so-called Conduent ruling where the Contracts Appeal Board (CAB) ruled that another vendor on a separate procurement was non-responsive because its CBE plan, though substantively compliant, was submitted after the date of the proposal.

As required by the CAB, DHCF's technical panel has initiated a revaluation of its scoring. However, because the Contract Officer for OCP is now required to apply the Conduent ruling to the managed care procurement, MedStar's proposal and those of two other unrelated procurements, by law, must be treated as non-responsive, thus eliminating any further review

As noted, the Mayor's has submitted language in the Budget Support Act which is currently before Council and will allow the revaluation for all proposals for DHCF procurements that were submitted prior to August 2020 to go forward in the evaluation process – the bill will **not** supplant the CAB's final ruling on DHCF's revaluation and scoring of the proposals, whatever the results. Nor does it minimize the CBE spending requirements for the impacted vendors who have submitted plans to allocate more than \$100 million annually to small and minority businesses based on the contracts. It is very important that the Mayor's BSA language be left unfettered in the current budget so that DHCF can orderly proceed with these procurements.

## **Conclusion**

Mr. Chairman this concludes my testimony on DHCF's proposed budget for FY2022. As has been demonstrated, the Mayor continues to fund health care through the Medicaid and Alliance programs at levels that support expansive coverage to promote critical access, as well as comprehensive services to ensure the enrollees receive the full range of preventive, diagnostic, emergency, specialty care and acute services.

My team and I are happy to address any questions from you and others on the health committee. Thank you for this opportunity to testify.